HS&RREPORT REQUEST FORM*

Provider Name				
Medicaid Provider	Number			
From Date of Service	ce (DOS)			
To Date of Service	(DOS)			
From Date of Paym	ent (DOP)			
To Date of Paymen	t (DOP)			
Type of Report			_SummaryPe	Detail
HS&R report to be received per			_ WEB	CD
Please note: Only e per the web. All oth detailed below.		providers can recei equest per CD and	•	•
Requested By				
Address				
Phone #:				
NOTES:				
Submit to:	Lanika Dancy		ldancy@dch.ga.gov	
Date Ordered				

Date Received	WEB	CD	
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* Please advise of \$30 charge for Summary and \$200 charge for Detail to non-Medicaid providers